HEALTH POLICY ISSUE BRIEF

APRIL 2014

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ENGELBERG CENTER for Health Care Reform at BROOKINGS

The Brookings Institution | Washington, DC

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The Future of U.S. Health Care Spending Conference
April 11, 2014

Alternative Health Spending Scenarios: Implications for Employers and Working Households

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Abstract

Scenarios for low or high rates of health spending growth have important implications for employers that provide coverage (or are on the margin for doing so) and the employee households that benefit from it. For small employers, whether or not coverage is offered is sensitive to premiums, with smaller effects for larger employers. The literature indicates that substantial portions of premium increases are shifted to employees as smaller wage increases and less comprehensive coverage. Innovation in benefit designs, network designs and policies on employer contributions appear to be making it easier for employers to quickly shift unexpectedly high rates of premium increases to employees. High-deductible plans have saved money but sacrificed some of the financial protection for households from expensive illness. The welfare of those getting coverage through employment is strongly affected by spending trends.

For those not insured by Medicare or Medicaid (or getting their health services or insurance through the Department of Defense or the Department of Veterans Affairs), most of their health care is financed through employment-based insurance (ESI) from either private or public employers. How this coverage is affected by spending trends being higher or lower will influence both the employers providing coverage and their employees, who will be influenced both by whether they are offered coverage, what they contribute when they enroll, the nature of the coverage that is offered and how it affects the rest of their compensation. It also affects federal and state revenues, since the exclusion from taxation to employees of employer contributions to coverage and a large part of employee contributions is among the largest tax expenditures. Outside of ESI, spending trends directly affect those who buy individual insurance coverage and those who are uninsured.

(Continued)

The author thanks Willem G. Daniel, Senior Research Assistant, Economic Studies at The Brookings Institution for valuable research assistance.

Abstract (continued)

A key factor in how the private sector responds to higher or lower trends in spending is the behavioral response by those employers who provide health coverage or are considering doing so. Some time ago, discussion by employers of rising health spending assumed that increased premiums for coverage was simply a burden that was being borne by the employers or their customers in terms of lower profits or higher prices, respectively. They fretted about international competitiveness from higher product prices. This was starkly at odds with economic theory, which predicts fluid tradeoffs between health benefits and other parts of employee compensation, meaning that, at least over time, higher health care spending is borne by employees in the form of less comprehensive insurance, lower wages or a higher share of premiums contributed by employees. Employers would point to difficulties in lowering wages, especially under collective bargaining agreements, and expectations for the comprehensiveness of insurance.

A lot has changed in recent years. A body of economic research has developed about behavior of employers with respect to health insurance provision and compensation. In addition, larger changes in many aspects of employment-sponsored coverage have been witnessed in recent years, especially sharp increases in deductibles, in some cases in conjunction with health savings accounts or health reimbursement accounts. Changes in other aspects of coverage in response to rising spending are also visible, with the potential to become very important in the future. Looser labor markets and greater pressure on employers to maximize profits may be factors leading to the potential of a more elastic response of employment-based coverage today than in the past.

I. Employer Responses to Spending Trends

Employers offer health benefits to employees for a number of reasons. For those employees in higher income tax brackets, the tax savings of funding health benefits from pre-tax earnings are substantial. The creation of risk pools through employer coverage enables almost all employees to afford coverage, including those who have or develop histories of poor health or high spending and those who are older. Finally,

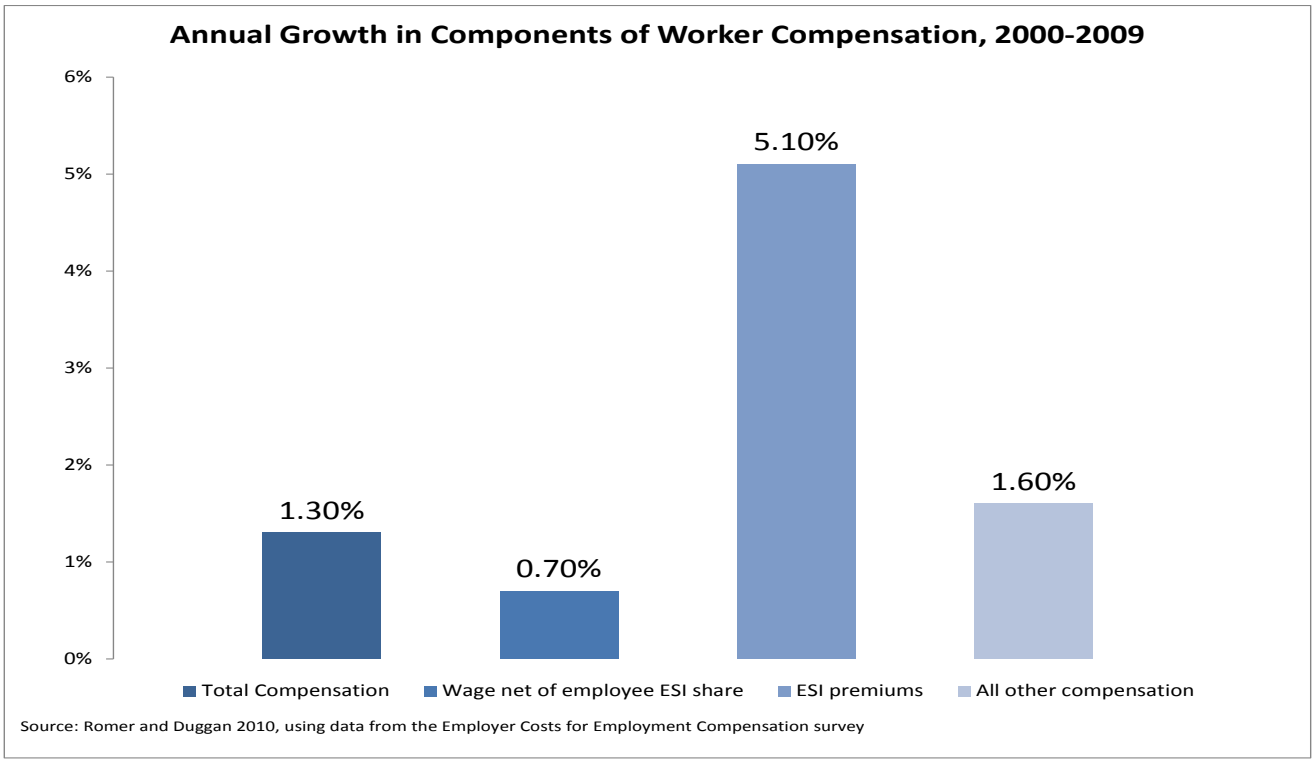
employers, especially larger ones, are in a position to purchase coverage at lower cost (the cost of insurance is the difference between premiums and claims paid—the inverse of the medical loss ratio) than individuals can.

The importance of these factors differs greatly for high-wage or low-wage employees. ESI is clearly very attractive to the former, making it a key factor in recruitment and retention. In contrast, low-wage employees are far less likely to be willing to sacrifice substantial amounts of other compensation for health insurance and Importance of these factors also varies by firm size. Smaller firms tend spend more for comparable coverage due to higher administrative costs and less market leverage with insurers. On average, their employees also earn less. As a result, they are less likely to offer coverage to employees and when they do, it tends to be less comprehensive. An implication of this variation is that as health spending rises more rapidly than employee earnings, large firms with high-wage workforces are likely to be less responsive in their decisions about offering health insurance and its comprehensiveness than smaller low-wage firms.

This variation by firm type is important in the literature on how employer offering coverage is influenced by exogenous aspects of premiums, which some studies have modeled with the tax price of health insurance. The best known study (Gruber and Lettau 2004) shows a high responsiveness by small firms (elasticity of -0.688) and a small responsiveness by medium firms (elasticity of -0.128 but not statistically significant) to the tax price of health insurance (virtually all large firms offer coverage). Using more recent employer survey data, Abraham, Feldman and Graves (2014) found a similar (slightly higher (-0.813)) responsiveness by small firms, but also a modest responsiveness by medium and large firms that is statistically significant. Noting that the large firms that did not offer coverage were in industries with low wages, they found a strong relationship between average family income of workers in an establishment and the offering of health insurance.

Research shows that substantial portions of insurance premium increases are shifted to workers. The Baicker and Chandra (2006), using employer survey data, estimated that for workers covered by employer-

sponsored health insurance, a 10 percent premium increase lowers wages by 2.3 percent, implying that the additional costs of coverage are fully shifted to workers. Romer and Duggan (2010) , in a blog for the Council of Economic Advisers, examined time series data from the Bureau of Labor Statistics' Employer Costs for Employee Compensation Survey for 2000 and 2009. They showed that while total inflation-adjusted compensation per hour increased at an average annual rate of 1.3 percent per year, hourly wages and salaries increased only at 0.7 percent per year.[1] In contrast, employer contributions for health benefits increased by 5.1 percent per year (see figure). Over the period, the fraction of total compensation going to employer contributions for health benefits increased from 7.4 percent to 10.9 percent.



Nyce and Schieber (2013) show that over many decades, total compensation increases have been in line with overall productivity increases, but due to increased spending for pensions and health benefits, wages have grown substantially more slowly. They focus on the different experiences by earnings decile. For the 2000-2009 period, the proportion of compensation gains going to health benefits starts at 24 percent for the lowest decile (few of these have health benefits), peaks at 37 percent for the fourth decile and then declines to

9 percent for the highest decile. The implication is that for many employees, growth in health benefits has substantially reduced wage increases.

II. Expanding Option Set for Employers

Over the last decade, the range of responses that employers have taken in response to rising health spending appears to have expanded. Some of them involve employment practices, while others involve the nature of health benefits that are provided. A number of changes in employment practices have the effect of reducing employer exposure to rising health spending. These include a shift towards part-time and contract employment and additional outsourcing of functions that are outside of the organization's core business, such as cleaning and maintenance. In each of these cases, the changes are being driven by broader forces than the challenge of rising health spending, precluding any statement that these are specific responses to the latter. But health spending is likely to be a factor. While these changing practices reduce employer exposure to rising health spending, it is also the case that the magnitude of these changes in practices will have some sensitivity to the rate of change in health spending.

Many of these changes are driven by the heterogeneity of wage rates within an organization. With requirements that all employees have the same eligibility requirements for coverage and, for those eligible, the same benefits, employers are limited in responding to the distinct labor markets for different categories of employees. Shifting to part-time and contract work for categories of employees and outsourcing low-wage functions is a way to diminish those constraints in responding to market forces.

The type of insurance that is offered to all eligible employees is undergoing many changes, with a significant part of the changes likely being in response to health insurance premiums increasing faster than overall compensation. Perhaps most important to date has been the size of the deductible. According to the KFF-HRET Survey of Employer-Sponsored Health Benefits (2013), the percentage of covered workers enrolled in a plan with a general annual deductible for single coverage of $1000 or more increased from 10 percent in

2006 to 38 percent in 2013. For those employed by small firms (3-199), the percentage increased from 16 percent to 58 percent, while the proportion for those employed by larger firms increased from 6 percent to 28 percent.

Another way of tracking changes in deductibles is to look at average deductibles. For those plans with a general annual deductible, the amount of the deductible for family coverage increased substantially, though varying by plan type. For HMOs, the average increased from $751 in 2006 to $1743 in 2013. Deductibles tend to be larger in PPO plans, but the increase was smaller in both absolute and percentage terms—from $1034 to $1854. One way of thinking about this is that norms as to the benefit design for employment-based coverage eroded over time, with a much greater variety in the percentage of claims paid by the plan as opposed to the patients who use services. Whether in response to rising health spending or to other changes in human resources practices, the benefit structure appears to have become a tool gaining more active use.

In contrast, the percent of the premium paid by the employee increased only modestly. From 1999 to 2013, the percent of the premium paid by the employee for single coverage role from 14 percent to 18 percent. For family coverage, the change was smaller—from 17 percent to 19 percent. The most notable trend was the decline in the proportion of plans where the employee does not make a contribution.

The emphasis of increasing deductibles over increasing the share of premiums paid by employees may reflect two considerations. First, only the former offers a constructive way to for employees to respond in a way that reduces health spending. Changes in patterns of health spending could reduce the burden on employees, although at the cost of more limited access to services and provider choice. In contrast, the only potential response to an increase in the employee share of the premium is to terminate coverage. For those with opportunities for coverage through a spouse's employment, the sacrifice would be modest. But for those without such opportunities, the loss of employer subsidies and tax benefits would mean that dropping coverage would be highly costly.

A more recent development has been innovations in provider networks, particularly limited networks. Small employers have been choosing insurance products with less choice of providers in order to obtain lower premiums. According to analysis by McKinsey & Co. (2013), 70 percent of the plans offered on public insurance exchanges created under the Affordable Care Act had limited networks. Although the numbers of people obtaining coverage on public exchanges to date is a relatively small part of the private insurance market, the experience to date likely has increased the overall number enrolled in limited network products by an order of magnitude, opening the door for further expansion in use of these tools. In other words, the substantial growth in experience with limited network plans likely will accelerate the movement of employers towards greater use of this tool, especially in the context of private exchanges (see below).

Although the public exchange experience with limited network plans has not been in place long enough for careful studies, the abovementioned McKinsey study indicates that premiums for plans with broad networks are 23 percent higher than those for comparable plans with limited networks. Articles in the trade press suggest an enthusiastic response from consumers obtaining coverage through the exchanges. Most of the consumers in exchanges are receiving premium subsidies, although the structure of the subsidies has been designed to be neutral with respect to choice of plans. This creates an environment far more conducive to limited network plans than the typical situations within ESI.

Another recent development has been private insurance exchanges run by benefits consulting firms and insurers, where an employer makes a fixed contribution for health insurance and employees choose from the plans offered on the private exchange. Although the approach has been developing over a number of years, many commentators are anticipating a rapid acceleration in use of this approach.

An array of factors has been mentioned behind private exchanges. An obvious one is to give employees a greater choice of health plans. This addresses a key criticism of the system of private insurance based on employment. It likely is particularly appealing to employers that have a very heterogeneous

workforce as far as skill and compensation levels and geographic location. Another factor involves outsourcing some human resources functions. The fact that private exchange managers have already developed the web sites and support for employees to choose plans is clearly a factor for some employers contracting with an exchange rather than simply increasing their own plan choice.

But the most frequently mentioned factor behind private exchanges is a desire to change the approach towards health benefits from one of defined benefits to defined contribution. Employers want to peg their increases in their contributions for health benefits to their trend in wages and salaries. This would follow the movement in retirement benefits from a benefit defined in relation to earnings history at the company to a defined contribution based on salary.

But note the evidence presented above about the ability of employers to shift increases in health insurance premiums that exceed wage increases into smaller wage increases. The reconciliation is not very difficult. First, researcher humility requires us to acknowledge that decision makers are either not aware of the research or do not have confidence in the results. While this is likely a factor, a more important factor is that shifting excess increases in health benefits to wages is not costless. Employers might see large advantages to keeping wage increases in line with productivity trends and having excess increases in health insurance premiums paid automatically by employees.

Such an attitude might appear to be inconsistent with the longtime experience (described above) of percentages of premiums contributed by employees being stable. But the difference with private exchanges is the ability of employees to keep their contributions from increasing by choosing a less expensive health plan. Like increasing deductibles, a defined contribution with a choice of plan allows for behavior to respond and limit the impact on the employee.

III. Implications for Households

Most of the implications for households or higher or lower spending trends come from changes in employer-based health insurance. To the degree that some employers respond to rising health care costs by not providing coverage, those employees without the opportunity to gain employer coverage through their spouse will have to either find coverage elsewhere, such as through individually purchased insurance or possible eligibility for Medicaid or CHIP. A few will be able to change jobs to one that offers coverage. Those eligible for subsidies under the Affordable Care Act could be better off depending on whether they are eligible for a tax credit and how it compares with their past employer contribution. Some will become uninsured. Employer shifts of the costs of rising health insurance premiums to employees through smaller wage increases will affect many more people but have smaller effects on most.

But changes in ESI benefits will have important effects on households. Higher deductibles will lead to different medical care decisions on the part of households, including using less care and opting for less expensive providers. Research on whether the reduced utilization is comprised of necessary or unnecessary services tends to indicate a mixture of both. In situations where utilization cannot be reduced, those who have increased deductibles will devote more of their incomes to medical care.

When the deductibles are very large in relation to family incomes or savings balances, insurance will provide a lot less financial protection to households than was the case in the past. Researchers have studied the prevalence of burdensome spending on medical care by defining it in terms of paying more than a certain percentage of annual family income, e.g. 10 percent, for medical care over a period of a year. Doty and colleagues (2008) documented an increase in the proportion of working age Americans that had difficulty in paying for care between 2005 and 2007 (a relatively prosperous period), but Cunningham (2012), studying data from a different survey from 2006 to 2009 (a period covering the recession), found that burdens did not increase due to many blockbuster prescription drugs coming off patent.

A final implication of spending trends for the household sector concerns taxes and public services. To the degree that rising health spending increases outlays for Medicare, Medicaid and subsidies to purchase private insurance on public exchanges, as well as increasing revenue loss due to the exclusion of employer and most employee contributions to health insurance from taxation to the employee, the household sector will ultimately face a result of lower spending for other government programs and higher tax rates.

IV. Role of the Affordable Care Act

A number of provisions in the Affordable Care Act will have an effect on how employers respond to rising health insurance premiums. The employer mandate, now partially delayed until 2016, will reduce somewhat employer ability to drop coverage (or not initiate coverage) in response to premium increases. This may shift some employer response to premium trends away from dropping coverage towards shifting the costs to smaller wage increases. An irony is that many working for smaller employers on the margin for offering health insurance would be better off if their employers dropped coverage. Many of these people have incomes low enough to either be eligible for Medicaid (at least in states that expanded coverage) or qualify for premium subsidies for private coverage purchased on public exchanges.

Premium subsidies under the Affordable Care Act are designed to increase automatically over time when health spending increases. They are pegged to the premium for the silver plan in the area with the second lowest cost and are designed to limit the percentage of income that goes to purchase health insurance. So the federal budget bears the risk of rapid increases in health spending rather than those individuals whose incomes are low enough to merit a subsidy.

The provision of the ACA most likely to have an effect on employer coverage is the Cadillac tax, scheduled to take effect in 2018. Higher spending trends will lead to an even larger impact. Although inspired by many decades of recommendations by economists to limit the amount of employer contributions for health benefits that are not taxable to the employee, the provision instead specifies a 40 percent tax on the portion

of premiums that exceed specified thresholds. The tax is levied on the insurer, which is not allowed to deduct the tax as a business expense. The effect is to cap the premium that can be charged for health insurance. This will limit the comprehensiveness of insurance, with the stringency of the cap varying by region according to health status, utilization patterns and health care prices. Numerous trade press reports indicate that large employers are already taking steps to avoid dislocation when the Cadillac tax takes effect in 2018. These actions are said to include raising deductibles and switching from defined benefits to defined contributions.

V. Conclusion: Future Health Spending Trends and the Private Sector

This analysis has shown substantial implications for employers and households for different rates of growth of spending. The literature shows modest responses in employer offering of health insurance overall, but with substantial responsiveness by smaller employers. It also shows substantial shifting of rising costs of health insurance to wages. Recent developments in health care financing suggest that employers have additional mechanisms in which to shift these costs to employees, especially the growth of high-deductible health plans. Should private insurance exchanges gain the traction that many are predicting, this will give further flexibility to employers, who likely will use them to not only offer employees greater choice in health plan, but also to fund them as a defined contribution. As has always been the case, the household sector has a lot at stake in health spending trends.

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[1] In this calculation, employee contributions to health benefits were subtracted from wages and salaries. If this had not been done, the increase in wages in salaries would have been 0.8 percent per year.